(Rev. 10/16) SLTC 241

State of Montana

Department of Public Health and Human Services

COMMUNITY FIRST CHOICE PERS REFERRAL FORM

☐ CFC PERS Initial Referral ☐ Change of PERS Provider ☐ Prior Authorization Renewal

☐ Ending PERS Services – Date: _____ ☐ CFC Discharge – Date: _____

Referring Agency Name: _____

Plan Facilitator Name: _____

Agency Address: _____

Contact Number: _____ Fax Number:_____

PERS Provider Name: _____Provider Medicaid ID# _____

Member Name: _____ Member Phone No: _____

Member Address: _____

Member Medicaid ID #_____ Member Birthdate: _____

Physician: _____Phone No: _____

Primary Diagnosis: _____ Diagnosis Code: _____

Prior Authorization#: _____ Date Span: _____

Service	Procedure Code	Mod	Current Units	Corrected Units	Rate	Effective Date
➢PERS Installation	S5160					
➢PERS Rental	S5161					

Comments:

Notification of Service Termination:

_____ _____

PERS Provider Termination Date

_____ _____

Member Name Date